



South Carolina Department of Health
and Environmental Control

Review of Systems Worksheet

Patient Name: _____ Date: _____

Please check all that apply to you:

1. General

- | | |
|--|---|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Unexplained hair loss (alopecia) |
| <input type="checkbox"/> Fever or chills | |

2. Eyes

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Vision problems (blurred vision, loss of vision) | |

3. Ears/Mouth/Throat

- | | |
|--|---|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Swollen glands in neck |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sore throat/pain when swallowing |
| <input type="checkbox"/> Dental difficulties | <input type="checkbox"/> Mouth sores |

4. Cardiovascular

- | | |
|--|---|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Leg pain in calf or thigh of leg |
| <input type="checkbox"/> Chest pain (sharp, crushing, or heaviness) | <input type="checkbox"/> Aching/Burning in legs |
| <input type="checkbox"/> Heart racing (palpitations) | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Sudden shortness of breath at night or lying down | <input type="checkbox"/> Swelling of legs (Edema) |

5. Respiratory

- | | |
|--|--|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cough/coughing up blood |

6. Gastrointestinal

- | | |
|---|---|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Increased appetite |
| <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Stomach pain |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | |

7. Genitourinary

Men and Women:

- | | |
|---|---|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Sores (vagina, penis, rectum) |
| <input type="checkbox"/> Pain when passing water (urination) | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Passing water more than usual (day and/or night) | <input type="checkbox"/> Bladder Infection/other infections |
| <input type="checkbox"/> Pain during sex | <input type="checkbox"/> Changes in sex drive (libido) |

Women:

- | | |
|---|---|
| <input type="checkbox"/> Irregular periods (menstruation) | <input type="checkbox"/> Painful periods (menstruation) |
| <input type="checkbox"/> Increased or too little bleeding during periods (menstruation) | |
| <input type="checkbox"/> Three or more yeast infections in a year | <input type="checkbox"/> Discharge from vagina |

Men:

- | | |
|--|--|
| <input type="checkbox"/> Discharge from penis (drip) | <input type="checkbox"/> Swelling in balls (scrotum) |
|--|--|

8. Musculoskeletal

- | | |
|--|--|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Limited motion of arms or legs |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Swelling/Redness If so, where _____ |
| <input type="checkbox"/> Numbness, tingling, or weakness in arms or legs | <input type="checkbox"/> Pain in calf or thigh |
-

9. Neurological

- | | |
|--|---|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Arm/Leg weakness |
| <input type="checkbox"/> New headaches | <input type="checkbox"/> Repeated bad headaches |
| <input type="checkbox"/> Headaches with vision changes | <input type="checkbox"/> Problems with memory or speech |
-

10. Psychiatric

- | | |
|--|--|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Seeing or hearing things (Hallucinations) |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Mood swings |
-

11. Endocrine

- | | |
|---|--|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Weight gain/loss |
| <input type="checkbox"/> Thirsty all the time | <input type="checkbox"/> Can not stand temperature changes (heat/cold) |
| <input type="checkbox"/> Increased facial hair (females only) | |
-

12. Lymph

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Swollen glands (armpits or groin) |
|--------------------------------------|--|
-

13. Skin

- | | |
|--|---|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Rash (palm of hands, sole of feet) |
| <input type="checkbox"/> Changes in skin | <input type="checkbox"/> Sores or rash on skin |
-

14. Allergies

- | | |
|--|---|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Allergic Reaction to drugs |
| <input type="checkbox"/> Hives/skin rashes | <input type="checkbox"/> Allergic Reaction to foods |
-

15. OtherPlease write in:
